epiTRENDS

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Syphilis Outbreak in King County and Increase in STDs Have Alarming Implications for HIV Transmission

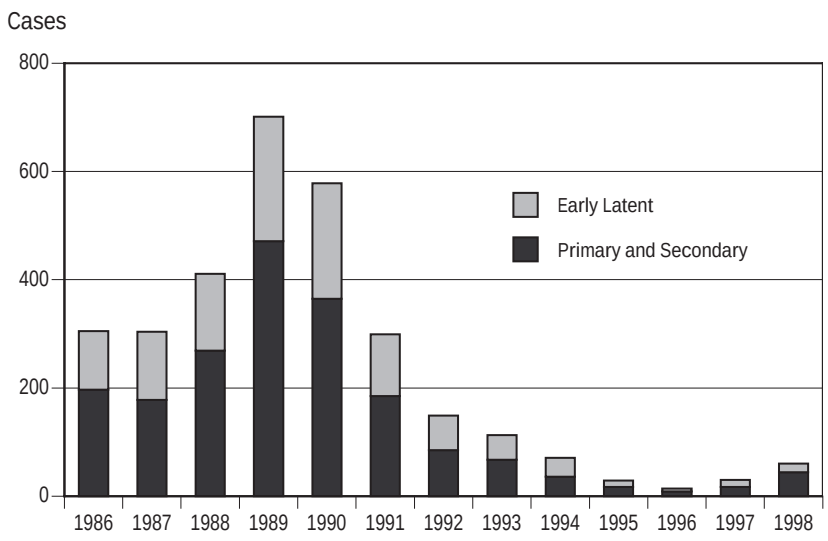
An outbreak of syphilis in King County that began last year and continues into 1999 points to the return of sustained transmission of syphilis and carries alarming implications for the transmission of human immunodeficiency virus (HIV). The 44 cases of primary and secondary (P&S) syphilis reported in 1998 (0.8 per 100,000 persons) and the 22 cases reported through March 1999 have occurred primarily among men who acquired the infection through unsafe sex with anonymous male partners.

The current situation differs in significant ways from the last major outbreak of syphilis in Washington State during the late 1980s. Reported cases of syphilis among men who have sex with men (MSN) declined from 81% of cases in 1973 to 8% in 1988. In 1989 reported cases of primary and secondary (P&S) syphilis peaked at 471 (9.9 per 100,000) (Figure). Most cases occurred among heterosexuals and related to the use of crack cocaine and the exchange of sex for drugs or money. Syphilis reached the lowest level ever recorded in Washington State in 1996 with the report of only 9 cases (0.2 per 100,000) of P&S and 5 cases of early latent syphilis. Case investigations during 1995–96 suggested that most of these infections were acquired outside the state and that transmission of syphilis was interrupted in King County, if not the entire state, during 1996 (1).

In addition to the rise in syphilis cases, a concurrent concern is an increase in *Chlamydia* and gonorrhea infections among MSM. The Sexually Transmitted Disease

Continued page 2

Figure: Reported cases of early syphilis in Washington State, 1986–1998



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Syphilis *(from page 1)*

(STD) Clinic administered by the Seattle-King County Department of Public Health at Harborview Medical Center reported 216 combined cases of *Chlamydia* and gonorrhea among MSM in 1998 vs. 108 in 1997. Data compiled from health care providers across King County raise equal alarm: reports of rectal gonorrhea in males increased from 6 cases in 1997 to 61 in 1998. Similar increases have been reported in other areas of the country (2). These data and findings from case investigations suggest that the increased frequency of unprotected anonymous sex is the likely cause of the observed changes in morbidity.

Links Between STDs and HIV

The current syphilis outbreak presents a serious community health problem, given that recent studies have demonstrated the following associations between the transmission of HIV and other STDs (3):

1. Persons infected with an STD have two to five times the probability of acquiring an HIV infection, if exposed.
2. The presence of a concurrent STD increases the probability that an HIV-infected person will expose others through exudates, ulcers, or other genital secretions.
3. A concurrent STD promotes replication of the HIV virus and accelerates the immunologic damage caused by HIV.

About 70% of the men infected with syphilis in King County during the current outbreak are also infected with HIV, as have been 20% of gonorrhea cases among MSM. It is unknown whether these indirect indicators of increased high-risk sexual practices are also associated with an increase in HIV infection rates. An important benefit of statewide HIV reporting, to begin this fall, will be a more timely way to detect increases in HIV infection and to identify and mitigate risk behaviors.

Many cases of syphilis among MSM have occurred among patients already receiving medical care for HIV infection. Such links are reminders for health care providers to regularly inquire about the sexual activity of their HIV-infected patients throughout the course of care, and to offer continuing counseling and referrals for reducing risks of transmission.

It is also important to test routinely for STDs (e.g., periodic syphilis serology, rectal and pharyngeal gonorrhea cultures, and rectal and urethral *Chlamydia* cultures), even if compelling clinical or historical evidence is lacking. Clinicians should also note that acquisition of an STD in an HIV-infected person may indicate behavior that presents an imminent danger to public health. In such cases, consultation with the local health officer to develop a confidential, client-centered intervention for risk reduction is encouraged and legally permitted.

Although other local health jurisdictions (LHJs) in Western Washington have not reported similar trends in morbidity, the Department of Health encourages health care providers and LHJs across the state to work together to ensure the approaches and goals listed in the table. ◆

Table: Department of Health recommended strategies for HIV and STDs

1. Communicate to patients the importance of being aware of one's own HIV status and that of sex partners and, if infected, the need to participate in informing past and current partners of their exposure and to discuss their HIV status with future partners prior to having sex.
2. Educate about the use of condoms at every sexual encounter, safe injection practices, and avoidance of anonymous sex and other high-risk behaviors.
3. Ensure ready accessibility to and application of STD screening, diagnosis, and treatment among HIV-infected persons, MSM, teens, and other high-risk groups (3,4).
4. Promote increased awareness of and immunization against hepatitis A and hepatitis B among MSM and other high-risk groups (5).
5. Provide confidential referral services for reaching the partners of persons infected with HIV.

References

1. Williams LA, Klausner JD, Whittington WLH, Handsfield HH, Celum C, Holmes KK: Elimination and reintroduction of primary and secondary syphilis. *Am J Public Health* 1999: (in press).
2. Centers for Disease Control and Prevention (CDC): Increases in unsafe sex and rectal gonorrhea among men who have sex with men—San Francisco, California, 1994–1997. *MMWR* 1999; 48(3).
3. CDC: HIV prevention through early detection and treatment of other sexually transmitted diseases. *MMWR* 1998; 47(RR–12).
4. CDC: 1998 Sexually Transmitted Diseases Guidelines. *MMWR* 1998; 47(RR–01).
5. CDC: Prevention of hepatitis A through active or passive immunization. *MMWR* 1996; 45(RR–15).

Surveys Show Decrease in Abortion Service Providers

In Washington State and nationally, the number of abortion providers began to decline during the early 1980s. In a 1996 nationwide survey, the Alan Guttmacher Institute (AGI) identified 2,042 hospitals, clinics, and physicians' offices that provided abortion services, fewer than recorded in any of the institute's 12 previous surveys. The decrease in service provision occurred primarily at hospitals and physician's offices rather than at specialized clinics. These surveys show that the abortion rate began to decline gradually during the 1980s and then declined more rapidly after 1990 (Henshaw 1998). *Continued page 4*

Monthly Surveillance Data by County

May 1999* – Washington State Department of Health

County	E. coli O157:H7	Salmonella	Shigella	Hepatitis A	Hepatitis B	Non-A, Non-B Hepatitis	Meningococcal Disease	Pertussis	Tuberculosis	Chlamydia	Gonorrhea	AIDS	Pesticides†	Lead§#
Adams	0	0	0	0	0	0	0	0	0	1	0	1	3	0/#
Asotin	1	0	0	0	0	0	0	0	1	6	0	0	0	0/0
Benton	0	0	0	0	0	0	0	0	0	14	0	0	3	0/15
Chelan	0	1	0	0	0	0	0	4	1	8	1	0	4	1/5
Clallam	0	0	0	0	0	0	0	1	0	7	0	0	0	0/0
Clark	0	1	0	3	0	0	1	1	0	39	6	3	1	0/6
Columbia	0	0	0	0	0	0	0	0	0	0	0	0	0	0/0
Cowlitz	0	0	0	2	0	1	0	0	0	0	0	0	0	1/21
Douglas	0	2	0	0	0	0	0	0	0	3	0	0	0	0/0
Ferry	0	0	0	0	0	0	0	0	0	0	0	0	0	0/0
Franklin	0	0	0	0	0	0	0	0	0	11	0	0	2	0/28
Garfield	0	0	0	0	0	0	0	0	0	0	0	0	0	0/0
Grant	0	0	0	1	0	0	0	0	0	10	1	0	2	0/#
Grays Harbor	0	0	0	0	0	0	0	0	0	7	1	1	0	0/#
Island	0	2	0	0	0	0	1	1	0	3	0	0	0	0/0
Jefferson	0	0	0	0	0	0	0	0	0	1	0	1	0	0/0
King	3	18	3	1	1	0	1	18	5	271	69	13	4	0/22
Kitsap	0	0	1	1	0	0	0	1	0	51	2	0	0	0/11
Kittitas	0	0	0	0	0	0	0	0	0	4	0	0	0	0/0
Klickitat	0	0	0	0	0	0	0	0	0	1	0	0	0	0/0
Lewis	1	0	0	0	0	0	0	0	0	4	0	1	0	0/0
Lincoln	0	0	0	0	0	0	0	0	0	1	0	0	0	0/0
Mason	0	2	0	0	0	0	0	1	0	3	0	0	0	0/0
Okanogan	0	0	0	0	1	0	0	0	0	12	0	0	3	0/#
Pacific	0	0	0	0	0	0	0	0	0	0	0	0	0	0/#
Pend Oreille	0	0	0	0	0	0	0	0	0	1	0	0	0	0/0
Pierce	0	3	0	0	3	0	3	4	0	210	63	3	1	0/47
San Juan	0	0	0	0	0	0	0	0	0	0	0	0	0	0/14
Skagit	0	0	0	0	0	0	1	1	0	23	4	0	1	0/#
Skamania	0	0	0	2	0	0	0	0	0	0	0	0	0	0/0
Snohomish	1	2	0	1	0	1	0	7	3	104	12	2	0	0/6
Spokane	0	0	0	0	0	0	0	0	1	80	9	1	2	3/31
Stevens	0	0	0	0	0	0	0	0	0	2	0	0	0	0/0
Thurston	0	6	1	1	0	1	0	0	1	3	0	1	0	0/9
Wahkiakum	0	0	0	0	0	0	0	0	0	1	0	0	0	0/0
Walla Walla	0	1	0	0	0	0	0	0	0	14	0	0	0	0/5
Whatcom	0	0	0	3	1	0	0	1	0	24	1	1	0	0/5
Whitman	0	0	0	0	0	0	0	0	0	12	0	0	0	0/0
Yakima	0	1	4	0	0	0	0	3	1	43	3	0	2	0/21
Unknown														0/0
Current Month	6	39	9	15	6	3	7	43	13	974	172	28	28	5/258
May 1998	6	30	10	52	7	2	5	37	101	882	142	25	41	14/338
1999 to date	16	155	38	107	24	7	31	438	98	4810	862	144	72	48/1474
1998 to date	20	127	47	386	38	10	31	123	33	4509	755	188	112	57/1579

* Data are provisional based on reports received as of May 31, unless otherwise noted.
† Unconfirmed reports of illness associated with pesticide exposure.
§# Number of elevated tests (data include unconfirmed reports) / total tests performed (not number of children tested); number of tests per county indicates county of health care provider, not county of residence for children tested; # means fewer than 5 tests performed, number omitted for confidentiality reasons.

WWW Access Tips

Pregnancy and abortion statistics for 1996 and 1997 are available on the Web site of the Department of Health: www.doh.wa.gov/EHSPHL/CHS/default.htm.

Reference

Henshaw SK: Abortion incidence and services in the United States, 1995–96. *Family Planning Perspectives* 1998; 30:263–270, 287.

Conference Alert!

The 6th Annual Joint Conference on Health sponsored by the Washington State Public Health Association is scheduled for October 4–6 in Spokane. The program brochure will be distributed in July. For information: http://www.business-link.com/wspha; Kay DeRoos, 206-362-4728 or dero101w@cdc.gov.

Abortion Data *(from page 2)*

Trends in Washington State

Trends in Washington State mirror the national experience, with some variations. Data from the Washington State Abortion Reporting System show that 91 facilities provided abortion services in 1980 compared to only 62 in 1997. The most pronounced decrease in the number of providers, from 76 in 1980 to 43 in 1997, occurred among physician's offices, hospitals, and smaller facilities (those peforming less than 400 abortions per year). In contrast, facilities (mostly clinics) that performed 400 or more abortions per year increased slightly, from 15 to 19 between 1980 and 1997.

Washington State's abortion rate for women aged 15–44 declined primarily during two periods: the first half of the 1980s and continuously since 1990. From 1980 to 1985, the state rate showed a more pronounced decline than the national rate. Since 1990 the declines have followed a similar slope, with the Washington rates consistently lower than the national rates. The most recent rates recorded are the lowest ever: 21.7 per 1,000 Washington women (a 30% decline since 1980) compared to 22.9 for the nation in 1996 (a 22% decline since 1980).

The caseload of abortion providers may also be changing. In Washington, facilities that performed fewer than 400 abortions per year accounted for about 24% of abortions performed in 1980 compared to about 9% in 1997. Concurrently, the percentage of abortions performed by those doing 400 or more abortions per year increased from nearly 76% to nearly 91%. Little change has occurred, however, among the largest facilities, those doing more than 1,000 abortions per year. Eight such facilities performed 59% of abortions in 1980 and 57% in 1997.

The decline in abortion services offered at physician's offices, hospitals, and smaller clinics raises concerns about access to care for some women, particularly in rural areas. However, the Alan Guttmacher Institute concluded that the drop in the national abortion rate was more heavily influenced by such factors as improved contraceptive use among teenagers. In Washington, further investigation into changes in abortion services is needed to determine the potential effect on women's health.

For more information about reporting requirements or to request copies of the reporting handbook or the Washington State Pregnancy and Induced Abortion Statistics report, please contact Jennifer Phipps at 360-236-4327 or jrp0303@doh.wa.gov.

Correction to May 1999 Issue

The table on page 2 with the article on surveillance of child deaths inluded errors for two categories of causes. Here are the correct data.

Causes of Deaths	Age in Years <1	1–4	5–9	10–13	14–17
Congenital anomalies	117	10	8		
Suicide				3	25

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